Working Group to Reinvent Medicaid
Wednesday May 27, 2015
4:00pm – 6:00pm
Meeting Minutes

I. **Welcome: Dr. Ira Wilson, Dennis Keefe**

Ira Wilson – this is in a sense the kickoff of phase II. Since the end of April when the recommendations were sent to the Governor, there have been two Senate hearings, two House hearings. My understanding is that there may be some votes on the article next week, either Tuesday or Thursday. There are still some moving parts – as you know some revenue estimates in the state were better than originally thought so this allows for suggestions to put some funds towards things like home and community based care. Time to see how it will play out. The next phase of this is really trying to design some structural reforms, a broader sense of direction over the next few years.

II. **Kick Off of Phase II:**

Secretary Roberts thanks the chairs, advises that today's meeting is to look over what our deliverables are for the next few weeks.
Matthew Harvey presents: [Presentation available on reinventingmedicaid.ri.gov]
Meeting dates for full Working Group: May 27, June 24 and July 8 at 4:00pm (locations TBD)
Working Session (optional): generally Wednesday mornings in June at 7:30am at the Brown School of Public Health, with two meetings the week of June 8 to be set.

III. **Review of Other State Reform Initiatives:**

i. Dr. Hittner, Health Insurance Commissioner, presents on OHIC Policy Initiatives and Goals (presentation available on reinventingmedicaid.ri.gov)
   - Maureen Maigret: Of those plans in the review noted on slide 14 does that include Medicare supplement?
   - Dr. Hittner: Yes.
   - Dennis Keefe: The task force also looked at the high deductible plans?
   - Dr. Hittner: Yes but in my mind it is too high; Carriers like it because there is less utilization, but is there less utilization because it is a problem for our patients.
   - Maureen Maigret: Have you looked at how the health department regulations, with a provision for co-pays for low income people are exempted somehow – not Medicaid level, but low income with a high co-pay for hospitalization. I think there is a regulation for that criterion.
   - Dr. Hittner: There are subsidies…

- Secretary Roberts: Yes, on the Exchange there are the subsidies, and there is a financial assistance plan for those who have trouble making their co-pays and deductibles.
- Hugh Hall: Point of clarification, I've been led to believe that your office has no oversight on Medicare Advantage plans? One of our concerns in the Long Term Care community is the heavy co-pays that these plans have, making us concerned that we are bankrupting 85/90 year olds. In Medicare Advantage plans they are front-end loaded, with a $150 a day co pay for the first 30 days. It seems wrong.
- Dr. Hittner: We have oversight on Medicare supplement plans, not on Medicare Advantage. There are many things that I think seem wrong which we need to address, and there is another area also that we do not have authority over that I am concerned about also: the self-insured.
- Hugh Hall: I am concerned for the patients but also on the provider side, receiving 2/3 of out reimbursement, instead of 3/3.
- Dr. Hittner: Agree and some of that we saw in the study. That whole topic is coming to the forefront, at a national meeting of Health Insurance Commissioners, out of concern yes for patients, but you are right also for providers.
- Ira Wilson: What advice do you have for this committee as we help think about Medicaid and how it should restructure itself. Based on what you know about the connects and disconnects, what advice do you have for what we should worried about or pitfalls?
- Dr. Hittner: I have been extremely involved in CTC, and what I would say is that, no matter what, it starts with the primary care of the patient, not alone, but it starts with primary care. Extension of primary care, like community health teams are now building. Complaints we receive often do not have to do with health care itself, but the environment around it. Deidre Gifford [the state's Medicaid Director] told me that she went to visit an Alzheimer's day care, and was very impressed with how patients were acting and treated. She asked what the difference was there for day care and for a patient that is institutionalized, and the answer is the care they get after they leave the center and before they arrive in the morning. We need supportive care and supportive communities. That's what I would advise.

- Dennis Keefe: Oversight of Medicaid managed care plans, and ensuring they are solvent, do you have authority over that?
- Dr. Hittner: Solvency? Department of Business Regulation (DBR) might, but OHIC does not, no. We work with DBR on that, they have the ultimate authority on that particular issue, but we are aware of what the reserves are in NHP, for example.
- Peter Marino: They are actually very rigorous, in the requirements that are set. And strong standards.
- Patrick Quinn: How do you determine what reserves ACO need?
- Dr. Hittner: We don't regulate those – we regulate the insurance therein.
- Patrice Cooper: There isn't a determination - ACOs are new entities and as they move towards risk need to discuss where that takes part.
- Dennis Keefe: Big issue in the industry, where should reserves reside. I don't think ACOs have reached a scale that it is a huge issue, but one that we should be prepared for.
- Sam Salganik: On the affordability standards there is really great work being done, some very much in line with what is happening here, and payment methodologies. I am putting in a plug for the last meeting of that committee which is June 18 and I hope EOHHS can send someone.
- Antonio Barajas: What would be the key components for the physicians to become part of that wider base of primary care?
- Dr. Hittner: That is the big question. Some discussions I am hearing, is that we have used the proverbial carrots a lot, perhaps we should consider using sticks now. Many groups still do not have Electronic Medical Records, for example, and if one does not it is hard to bring their system forward. We have a lot of work to do with that, but the carrots and sticks I think are a conversation to be had.
- Maureen Maigret: On these standards is it the health plans responsibility for compliance?
- Dr. Hittner: That is within our office, we have quarterly meetings with our carriers and all the standards are in there.
- Tom Kane: What is your concern about self-insured groups?

- Dr. Hittner: As moving from 0-50 to 0-100, the numbers are going up. Some are not providing insurance and risking just paying a fee. If something goes wrong, however, that is a huge cost. We also believe that the more and more self-insured we have, it will make it harder for them to keep rates under control.
- Tom Kane: Businesses look at groups as a means of surviving, insurance with a reputable carrier. Groups who have been around for a long time who have saved a lot of money. Bigger groups, but there is a fair amount of money there. I worry about businesses being able to make decisions in their own favor, trying to do due diligence, but while a good business decision it could be harsh.
- Dr. Hittner: We have our ability to monitor, and express concerns for our companies and our people.
- Ira Wilson: We have aggressive goals to really transform the way we look at our system. How important do you think it is for Medicaid to be moving along in parallel with the populations that you regulate? I get nervous that Medicaid is doing one thing, and commercial insurance is doing something else. From your perspective, how important is it to be more aggressive on the Medicaid side.
- Dr. Hittner: Jennifer Wood is about to speak to you about the SIM grant, which does address those issues and our ideas on that.

ii. Jennifer Wood, Deputy Secretary EOHHS, presents on the State Innovation Model [presentation available at reinventingmedicaid.ri.gov]
    - Tim Babineau: On slide 35, where did those numbers come from?
    - Jennifer Wood: This was the federal government, but we have had a process of reallocating the spend discussions within the steering committee. There are specific commitments within the grant document for each project, but we will ask the steering committee to revisit those before we procure the efforts. Funded and revaluated.
    - Dennis Keefe: When I see the definition that you want 80% invested in some kind of value based purchasing system, where would some of the other innovations fall? Are they under the umbrella of that approach? I am concerned that it is the least transformative.

- Jennifer Wood: We look to the terms of the grant application each time we consider these commitments. Anything that is not a direct FFS payment is therefore on the other side of the line – that is the weakest version of what we mean by 80% of value based purchasing. We know that what we mean is not FFS and moving along the spectrum into shared savings into full accountable care.
- Maureen Maigret: I think that is a really good question – how do we translate it all to consumers.
- Jennifer Wood: I know that we have done that, as my toughest audience is my dinner table. Describing it to my Medicare Advantage 92 year old mother was a challenge, but saying right now every time you go to a doctor, you pay on a per widget basis. What we would like to do is pay a panel of professionals to keep you healthy. That is fundamentally the layperson's definition.
- Linda Katz: I wondered how the programs at Department of Health will fit in with the SIM?
- Jennifer Wood: There is a strong subtheme in the SIM to make sure that our SIM investments support that work and that there are some elements of the transformation center work that are cognizant of that work. The form and how those will roll out depends largely on what the plan states. Depending on the strategic plan in the grant, that should be released January 2016.
- Sam Salganik: Are you looking at harmonizing measures across health care?
- Jennifer Wood: Just had that discussion this morning, planning for the June 11 meeting of the steering committee and how they should approach harmonized measures in RI. Usually the grizzly bear at that table is Medicare, and the question is whether or not CMMI will support us in having Medicare with different measures than there typically are. Come up with measures that we want to use and get CMMI to agree.
- Dale Klatzker: RI is a change resistant state, a risk resistant state, all the plans are directionally right on, but when it comes down to actually letting people do this, we throw up any barrier and obstacle we think of - I do not know the concrete proof of concept to transform. Someone has to take a step to do something, and take a leap of faith doing it – that is what I worry about, profile in courage to take that leap of faith.

- Jennifer Wood: The question is 'you and what army,' and I will answer it this way: We applied for the SIM and we received funds that we can apply to these levers. The other thing you may see are some disparate efforts. What I am seeing are efforts that are coming together, a number of things going for us we did not have five years ago or even three years ago.
- Holly Cekala: On the slide referencing behavioral health, has housing discussions come in with a population health plan?
- Jennifer Wood: Yes, hard to bring this all into slides. We absolutely want to say that our biggest focus for population health on this is behavioral health. Through the SHIP process it became clear we had a lot of efforts in other areas, but not a lot of knowledge base on what to do in the behavioral health realm. That is why we separately called that out as something to plan on and focus on this year. Developing supportive housing, developing community supports. That's why everywhere you see population health plan is population health and behavioral health.
- Chuck Jones The $20 million, considering the size of the Medicaid budget also, will this SIM plan recognizing ideas and suggestions for the delivery system, to OHIC, or EOHHS, etc. for execution?
- Secretary Roberts: These are strategic investments not operational support. Help build the system we are looking for, need to be strategic to use these funds in league with other efforts going on in our environment. This is a grant intended to build state capacity around health reform.

iii. Elizabeth Roberts, Secretary EOHHS, presents on the Healthcare Leaders Compact [presentation available at reinventingmedicaid.ri.gov]

- Patrick Quinn: We created the Health Insurance Commissioner in 2005, we created CurrentCare, and we have a lot of ability to build from that.
- Linda Katz: I am confused with how this will fit in with the work of the SIM? It doesn't seem like current innovation in Medicaid is discussed in here?
- Secretary Roberts: This group was more of a thirty thousand foot view. It is not a plan, rather a call to action, and a request for the Governor and new administration to renew an effort for better Heath Care in RI. Really thinking about the big institutional players. This document is a call to action and commitment by

this group to create a destiny and a vision for our health care system in RI – not a unique focus on Medicaid, but important to think about what else is happening in RI. We infrequently have varied physicians at the tables around the state, but this group had many physicians in the room. It was not a consumer based group, so no consumer advocates, but that was called out as a main area of focus.

- Ira Wilson: We wanted to be clear to all those around the table and to the audience that we want to build upon the expertise and the efforts of late, not reinvent the wheel. Get your thoughts on what else is being done, see the resources, and go forward. Remind everyone what has happened.
- Dennis Keefe: I would add that this group, those who signed the compact, are not a group that frequently agrees on issues. But the compact they signed was unifying. Consistent with a lot of the conversation that we are having around this table here.
- Linda Katz: Talking a lot about value based purchasing, it is mentioned in different percentages around different efforts. We should look at where we start, where we want to go, and try to align those efforts. How would we measure it? It feels like we need to see what value based purchasing we have in Medicaid.
- Secretary Roberts: You are correct, and we started those conversations on the Medicaid side a bit this morning at the working session. The issue that came up on end of life care, that is a topic that hits in a number of areas. Almost a social conversation that is reflected in our payment and delivery system model. This group here shows leadership, a commitment to build a strong health framework and a call for partnership with the state, and the Governor.
- Elizabeth Burke Bryant: I want to build on Ira's point, building on work that has been done, build on framework – and the alignment which Jennifer noted. I cannot not mention the success story of children's health insurance coverage. We have to build up on and look at success stories we have had in our own state. Just last week, CMMI issued a report that assessed state performance overall, perinatal, children and adolescent care, and RI was far and away the best. Have a lot of work to do, I am not blind to the fact that we do, but we have very hard work to getting to be successful in

efforts like this noted in the CMMI report. Helpful lessons to be learned.

- Chuck Jones: Going back to comments around value based purchasing and what that means. I think we need to be clear about what levels we set and what risk is taken for performance. What level of risk we expect those partners to take – at some point you get down to a provider level, and FFS may not be a bad approach if you have a component of the health care system that someone comes to work every day and they need to do a certain job. If we back the managed care work all the way up, we pay a per member per month (PMPM) to deliver health care, with the majority of risk on managed care organizations (MCO), we spend a lot of time talking about value and risk and disparaging FFS, but at some point need to see how we define that.
- Ira Wilson: Profound and important questions, and I feel that we need to discuss those, perhaps at our Wednesday AM sessions.
- Patrick Quinn; Providers developed insurers to get rid of some risk, that is the birthplace of BCBS, created an income stream. History has its layers.
- Ira Wilson: All agree we need to figure out what to do and how to do it.
- Maureen Maigret: When I look at some of the requirements, and Medicaid looks for 80% payment in an alternative payment system. It assumes that would be savings in a value based system.
- Dennis Keefe: Agree pivotal, tee-ed up well by Chuck, I would like to have this discussed next Wednesday morning.

IV. Public Comment

a. Tina Spears, RIPIN: "Just in remembrance of the consumer, patient perspective in every conversation. Consider consumer protections in these high level discussions, in narrowing of networks, in all aspects, remember the patient."
    i. Ira Wilson: All these models require more patient engagement, and new patient engagement to be successful.
b. Retired social worker: "You are asking the ill to suddenly be very rational about something physically debilitating and tiring. A problem I see is that we do not understand the services being delivered now. When out in the home itself you have high school dropout CNA or home maker who has serious limits on their ability to help. It is 6pm, and many people have been fed, bathed and put to bed, because that CNA wants to go home, even if the patient didn't want to go to bed. Medicaid is considerably different than private insurance. The poor

and the chronically ill have to deal with this all the time. The state provides services 9-5, but it's a 24/7 environment for the patients."

c. Karen Estrella: "I am wondering if there have been conversations around how DME and supplies are paid for – is there discussion amongst this group on equipment?"
    i. Matt Harvey: Looking at payment for services broadly, inclusive of, nothing specific to DME per say, but open to look at ideas on change if you have them.
d. Matt Trimble: "Mandatory enrollment on managed care on the provider side, my feeling is that if we do this right, work the MCO in the right way, and what we reinvent hits the triple aim, why do we need to mandate enrollment on the managed care side. The budget article takes away the ability to opt out of FFS."
    i. Matt Harvey: The general trend has been to move more services out of FFS and into managed care. Fair question, but the article just augments existing language.

V. Adjourn – Thank you and conclude.